MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Work Out Work Hardening, Inc. 4110 Cedar Lake Dr. Bldg. B, #201-202 Dallas, TX 75227	MDR Tracking No.: M4-03-7505-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Travelers Indemnity Co. Box 05	Date of Injury: Employer's Name: Insurance Carrier's No.: 039CBAUE3675

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
07/22/02	**07/22/02**	**97750-FCE**	**$300.00**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated June 3, 2003 states in part, "…This letter is requesting your help in receiving full compensation for services provided to [injured worker]. We have not received payment for the following services provided on 07/22/02. 97750-FC…In summary, please review all documenta of procedure closely…"

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent did not submit a position summary.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 97750-FC for date of service 07/22/02, payment exception code of "F, TX26 – this procedure/service code is reimbursed based on your state workers compensation medical fee schedule; per the Texas Fee Guideline, facility capacity evaluations are allowed 3 times per injured worker. The first FCE is reimbursed at $500, the second at $200". Although the carrier did not submit convincing evidence that there was more than one FCE, per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(E)(2)(a) the requestor did not submit the required summary report as required by the Medical Fee Guideline. Reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
7/22/2002	97750-FC	$344.00	$0.00				
				Total Left Column:			$344.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Ordered by:

Authorized Signature	Typed Name	Date of Order
	Marguerite Foster	01-13-05

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____